IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF TENNESSEE
AT NASHVILLE

MELISSA WILSON, et al., individually and on behalf of all others similarly situated, Plaintiffs, v. DARIN GORDON, et al., Defendants.	Civil Action No. 3:14-CV-01492 Judge Campbell Magistrate Judge Bryant **PLAINTIFFS' REPLY IN SUPPORT OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION**

INTRODUCTION

Plaintiffs seek nothing more than for Defendants to take responsibility for their state Medicaid program, and to ensure that the rights of all TennCare applicants be honored and respected. Notwithstanding Defendants' claims to the contrary, this is their legal obligation, and fulfilling their statutory duties will not cause any significant disruption to the current system.

Certainly Tennessee could have avoided the problems some of its citizens now face in enrolling in TennCare if they had created a more workable and thoughtful system, as the Bluegrass State aptly demonstrates. *See In Kentucky, a Glimpse of Health Insurance Help*, N.Y. Times (Nov. 5, 2013).[1] And Tennessee has shown a willingness and ability to do right by some target groups, such as those in the CoverKids program, which they candidly acknowledge in their supporting declarations is not complying fully with the new ACA requirements, but is doing so in a way that ensures no one who is eligible is denied, even if that means that a few persons who are not eligible may now be getting enrolled. Long Decl. ¶ 16. Yet when it comes to the

[1] Available at http://www.nytimes.com/news/affordable-care-act/2013/11/05/in-kentucky-a-glimpse-of-health-insurance-help/.

TennCare program—the program designed especially to help the elderly and young families who are on the edge of or in poverty—they barely acknowledge that the system is *not* working for some of its citizens, and protest that they cannot do anything to fix these problems.

Plaintiffs are not asking the Court to order Defendants to start over, nor even create a new "door" to handle new applications. All Plaintiffs seek is to ensure that, *when applications go beyond 45 or 90 days*, there is a process in place to address these excessively-delayed cases. Defendants' fear that this will result in tens of thousands of persons abandoning the current system to attempt to take advantage of any injunctive-ordered relief defies all logic; the injunctive relief would apply only to those who have gone through the current system and who have not received an answer. And since Defendants have already elected to consolidate the ability of the public to interact with TennCare through a single call center—the Tennessee Health Connection ("TNHC")—it is impossible to imagine how mass confusion could occur. The worst that could happen would be that people would call TNHC and they would be told the same thing they are told now: if they are new applicants for anything other than non-MAGI categories of CHOICES and the Medicare Savings Program ("MSP"), they must apply through the FFM. Of course those who would be calling are likely already calling TNHC to ask for an update on the status of their application or to ask how to apply anew, so even this new "burden" is dubious.

Defendants' dread of backlogs also cannot be credited. Tennessee wishes to claim it is doing better than most other states because it does not have backlogs, but the only reason Tennessee does not have a "backlog" is because they do not have any "log" at all—they refuse to accept and process applications for people having difficulties in their current system, much less allow enough people into such a system to create a backlog. And even if a backlog does emerge, which is to say, if after creating a process to help individuals who are being delayed beyond 45

or 90 days it becomes clear that there are people being delayed excessively, this ugly fact will shed light on what is already happening; it will not be a new problem. Far more important, it will permit the State to address this problem so that persons who are currently lost in the process will finally get help.

Defendants also contend that they have no legal responsibility for what is happening to those who are being forced to live without health coverage as they linger for months waiting for a decision, and attempt to place all the blame on the federal government. Federal law and the Center for Medicare and Medicaid Services ("CMS") take another view. CMS has been working for months with Tennessee to try to encourage Tennessee to take responsibility for its failings, and to take actions to protect its citizens who are applying. That is the central theme of the June 27, 2014, letter from Director Mann—to identify the numerous continued systematic failings by the State, and to provide concrete and workable solutions, "including manual MAGI processing (with tools that can facilitate this processing that can be readily adapted for Tennessee) and hiring additional staff to assist with application processing (for which enhanced Medicaid matching funds may be available)." Ltr. from Mann to Gordon (June 27, 2014) (Ex. 14 to Brooke Decl., ECF No. 4-1 at 123–25 of 125). Yet Tennessee has scorned these advances and refused to engage on the issue of addressing applications for TennCare that are overly delayed.

Certainly the roll-out of the ACA has faced complications, but it was also foreseeable, certainly now ten months after implementation began. Tennessee has steadfastly refused to take common-sense measures to address these delays and ensure that its citizens can continue to access the vital Medicaid program; it remains the only state, even among other "determination states" that delegate MAGI determinations to the FFM for all applicants applying through that door, that has no system in place to accept applications for the majority of Medicaid categories

and process these applications.[2] And while TennCare would like to blame the FFM, some members of the class do not even go to the FFM to get TennCare coverage. For example, the CHOICES and MSP programs do not involve MAGI determinations, and are handled directly by TennCare. Delays in these programs cannot possibly be attributed to anyone outside of the State. Yet these individuals also are facing interminable delays.

Actions speak louder than words. After this lawsuit was filed, and notwithstanding their protestations that they cannot possibly address this problem for fear of upending the entire system, Defendants have begun implementing a work-around for people Plaintiffs' counsel bring to their attention, although they have insisted that this process be capped at 100 applications. Long Decl. ¶ 12. Defendants have helped the named Plaintiffs through this process. They have helped CHOICES applicants through this process. They have helped people caught up in the federal Marketplace through this process. There are problems with this approach (including an arbitrary cap of 100), but it is working. In other words, the State has demonstrated it *can* help persons who are delayed beyond 45 or 90 days. And any concern that there may be "too many" persons in this situation cannot be heard—Defendants repeatedly insist the number is at most a "small percentage," and regardless of the actual size every one of these persons is having their legal rights violated. The State must do what it can to help them.

SUPPLEMENTAL STATEMENT OF FACTS

Interim Plan to Help Delayed Applicants While Preliminary Injunction Motion is Pending

Before this lawsuit was filed, advocates assisting individuals with healthcare applications referred over 200 individuals to TennCare who were having difficulties enrolling. Hagan Decl.

[2] *See* Gaskill Decl., Ex. 2.

¶¶ 5–6 (ECF No. 53). TennCare was able to enroll only a "majority" of these individuals in either CoverKids or TennCare, and determined that some were ineligible. *Id.* ¶ 7.

After the filing of this case, Defendants immediately solicited relevant information for the named and initials-only Plaintiffs, which Plaintiffs' counsel promptly provided, and shortly thereafter Defendants began enrolling Plaintiffs into TennCare; at this time all named Plaintiffs are enrolled. Hagan Decl. ¶ 13.[3] Defendants also reached out to Plaintiffs' counsel and agreed that if other individuals came to Plaintiffs' counsel's attention, Defendants would attempt to process them as well. Hagan Decl. ¶ 12; Zampierin Decl. ¶ 3. They represented that, for now, they would attempt to resolve only the first 100 applications, and they asked that Plaintiffs' counsel not "broadcast" that this was happening. Hagan Decl. ¶ 12; Zampierin Decl. ¶¶ 3–4. Under this system, Plaintiffs' counsel have been referring members of the potential class who have been delayed over the statutory period to Defendants, and have identified 57 TennCare applications to Defendants, involving 89 individuals, 19 of whom are newborns and 70 of whom are other children or adults. Zampierin Decl. ¶ 5. This includes two CHOICES applicants and two MSP applicants. *Id.* Many of these 89 individuals have also been delayed for months without a determination.[4] Seventeen of the newborns have been enrolled, including the five named Plaintiffs, and 15 of the non-newborns have been enrolled. Zampierin Decl. ¶ 6.

Class Incudes CHOICES and MSP

"CHOICES" is TennCare's program for long-term care services for elderly (65 years of

[3] Since submission of the Hagan declaration, the remaining Plaintiffs T.V. and D.A. have been enrolled.

[4] *See, e.g.*, LeCompte Decl. ¶ 2, ¶ 11 (waited five months before enrollment); Simpson Decl. ¶5, ¶ 21 (Raymond Simpson waited 170 days before enrollment); M.A.B. Decl. ¶ 7, ¶ 12 (waited 220 days before enrollment); J.M. Decl. ¶ 3 (has waited 205 days for a determination); Murphy Decl. ¶ 2 (has waited 8 months for a determination); Corbin Decl. ¶ 4 (has waited 97 days for a determination); J.F. Decl. ¶ 6 (has waited 216 days for a determination).

age and older) or disabled (21 years of age and older). *See* TennCare, *LTSS Gives CHOICES*, http://www.tn.gov/tenncare/long_choices.shtml (last visited Aug. 21, 2014). MSP is the Medicare Savings Program, designed to help with Medicare payments, which is administered through TennCare, Tracy Purcell Decl. ¶ 2 & n.1 (ECF No. 55). Defendants argue in their opposition to preliminary injunction that these categories are not a part of Plaintiffs' class, but that argument is mistaken; many CHOICES and MSP applicants have also been delayed beyond the requisite 45 and 90 day periods that comprise the proposed class definition in this case. For example, the following are putative class members and have been identified to Defendants as needing a determination:

M.A.B. is the attorney-in-fact for her son, a 39 year old disabled man. M.A.B.'s son suffered a traumatic brain injury when he was 17 years old. As a result, he has serious mental and intellectual disabilities. M.A.B. Decl. ¶¶ 2, 3. In December of 2013, M.A.B. applied for TennCare and Medicaid Savings Program on behalf of her son by submitting an application to the Tennessee Department of Human Services, which began a perplexing process where applications were lost, resubmitted, and not processed. *Id*. ¶¶ 7–11. M.A.B. resubmitted the form on July 25, 2014. Id. ¶ 11. After Plaintiffs' counsel submitted M.A.B.'s son's name to the State on about August 12, 2014, they finally received an affirmative response and coverage on August 18. *Id*. ¶ 12.

Matthew LeCompte is a disabled man living in Knoxville, Tennessee. LeCompte Decl. ¶ 1. Matthew lives with cerebral palsy, hydrocephalus, and severely impaired vision. *Id.* ¶ 3. He has a cerebral shunt implanted in his brain to drain the fluid and prevent dangerous swelling, and is confined to a wheelchair and dependent on the care of others to meet his daily needs. *Id.* ¶¶ 3–4. Matthew's mother applied for the TennCare CHOICES program on behalf of Matthew on

March 11, 2014, in order to allow him to attend a program at the Cerebral Palsy Center in Knoxville after he finished high school. *Id.* ¶¶ 2, 5. Instead, while they waited for a determination of Matthew's eligibility, either his mother or father had to be home at all times and provide constant care. *Id.* ¶ 8. After Plaintiffs' counsel submitted Matthew's name to the State on about August 4, 2014, his application was finally approved on about August 12, 2014—approximately five months after it was submitted. *Id.* ¶ 11.

Raymond Simpson applied for TennCare CHOICES through his son, Derrick Simpson, who is his caretaker and has medical power of attorney. *Id.* ¶ 1. He applied for TennCare CHOICES on February 24, 2014. *Id.* ¶ 23. Raymond, who is 75 years old, suffers from rheumatoid arthritis and cardiovascular disease, and has suffered five strokes that have left him with very limited use of the left side of his body. *Id.* ¶ 3. In fact, he has suffered two strokes and been hospitalized twice since he applied. *Id.* ¶ 23. His wife suffers from Alzheimer's disease, sarcoidosis and paranoia, and requires constant supervision to ensure that she does not injure herself or others. *Id.* ¶ 2. Derrick and his partner have moved into his parents' home to provide full-time care for his parents since January of 2014. *Id.* ¶ 4. They had to shut down their business and live off of their savings, even selling their personal vehicle to help provide financially for his parents to make ends meet. *Id.*

Derrick called TNHC many times to attempt to obtain an eligibility determination for his father or find out why the application was still pending. *Id.* ¶¶ 10, 11, 15. He was told on multiple occasions that he would have to submit new financial eligibility applications for Raymond. *Id.* ¶¶ 15, 17. Derrick's mother, whose application was submitted on the same day, obtained a determination much earlier—and the financial information portion of the application was identical to Raymond's. *Id.* ¶¶ 7, 8. On August 13, 2014, Derrick was told that Raymond had

been approved for TennCare Choices, but when Derrick contacted the Tennessee Health Connection to try to have his father put on the same managed care organization as his mother, he was told that there was no record of his father being eligible for TennCare. *Id.* ¶ 21. Plaintiffs' counsel submitted his name to the State on August 14, 2014. Derrick received a notice on August 15 that Raymond had been approved effective August 15, 2014, with no backdating. *Id.* ¶ 22.

Irreparable Harm to the Class is Continuing

Defendants also argue that there is no classwide injury or irreparable harm. As noted below in the legal argument, this is incorrect as a matter of law. But again, putative class members have been presented to the State by Plaintiffs' counsel who have medical needs that are logically representative of the class as a whole.[5] For example, the following individuals have been presented to the State:

Putative class members **M.G.** and **A.G.** are the children of **J.F.**; M.G. suffers from progressive scoliosis, a medical condition that causes her spine to curve and worsens over time and which requires surgery, and A.G. lives with debilitating migraine headaches that come on frequently, sometimes as much as twice a week, and is going without the recommended medication. J.F. Decl. ¶¶ 2, 4, 5, 8, 19. J.F. applied for TennCare on behalf of her children on January 17, 2014, but is still waiting after contacting Tennessee Health Connection repeatedly. *Id*. ¶¶ 6, 12, 14, 16. J.F. has scheduled and canceled M.G.'s surgery twice already, with the third date of August 26, 2014 rapidly approaching. *Id.* ¶ 10, ¶ 13, ¶ 15. During this time, M.G.'s scoliosis has continued to get worse. In 2013, M.G. played three sports at school, but because of the pain cause by her scoliosis she has had to quit them. M.G. can currently only walk for fifteen

[5] The named Plaintiffs' experiences also show the type and high likelihood of irreparable injury to members of the class awaiting eligibility determinations. *See* Pls.' Memo. in Support of Mot. for Prelim. Inj. 9–15; 18 (ECF No. 5.)

to twenty minutes before she has to rest. The pain is so constant that M.G. can find little reprieve, reporting pain when she sits, stands or sleeps. *Id.* ¶ 18.

Putative class members **J.M.** and her son **A.W.** applied for TennCare on January 28, 2014, but remain without a determination being told by the FFM that their application had been sent to TennCare, and assurances from the TNHC that their case was being "escalated." J.M. Decl. ¶¶ 3, 5. A.W. is four years old and lives with sickle cell anemia, a disease that has chronic and life threatening complications. To prevent and to combat these complications, A.W. requires extensive treatment, but they have not been able to afford and thus have discontinued the recommended doctor's visits, prescriptions, and treatments. *Id.* ¶¶ 2, 4, 6, 7. A.W. was recently hospitalized for three days because of a sickle cell crisis. A.W. had a fever and the doctors at the hospital were concerned about the potential for a life threatening bacterial infection. Before being hospitalized, A.W. had a fever for about a week. J.M. waited to take A.W. to the hospital because she was worried about accumulating more debt that she knew she could not afford. *Id.* ¶¶ 8–9.

Putative class member **Timothy Murphy**, his wife and three minor children applied for TennCare in December of 2013. The FFM has told Murphy that his family's application is complete and has been passed on to Tennessee. Murphy has contacted the TNHC at least three times since then. Each time he has called he has been told that his application would be "escalated" and that the family would receive a determination soon. Murphy and his family have yet to receive a determination from the state. Murphy Decl. ¶¶ 1–4. Murphy has been diagnosed with stage four cirrhosis of the liver, a potentially fatal illness. Since his diagnosis, he has been unable to see a doctor or receive any treatment. *Id.* ¶¶ 8, 9. While Murphy has struggled with his own illness, he has also had to deal with medical emergencies for his children. One son broke his

wrist in an accident while playing. Murphy took him to the emergency room to receive care, but the family opted to purchase his son a wrist brace from a store instead of receiving one from the hospital in order to avoid more medical costs; Murphy's son is still wearing the brace, and has not been brought to follow up appointments because of a fear of accruing more medical debt. *Id.* ¶ 5. Murphy's other son was severely injured, receiving a puncture wound, and visited the emergency room where he received treatment and was bandaged by the hospital staff. The staff recommended that the son have his bandages changed and wound inspected by a doctor. Murphy's family could not afford to see a doctor, so they changed his bandages themselves. *Id.* ¶ 6.

* * *

Certainly each of these examples, as well as those of the named Plaintiffs, have unique aspects. But they also clearly establish the irreparable harm the class members are suffering while they await a determination on their TennCare applications.

ARGUMENT

Plaintiffs are likely to prevail on the merits of their claim. The Sixth Circuit recognizes a private cause of action to enforce 42 U.S.C. § 1396a(a)(8)'s requirement that applicants be given a reasonably prompt determination on their Medicaid application, § 1396a(a)(3)'s requirement that applicants be given a hearing when they believe their application has been delayed, and the accompanying regulations. Defendants, as the single State agency in charge of TennCare, are responsible for ensuring these rights are protected, and by failing to do so Defendants have caused injury to Plaintiffs. Defendants furthermore may redress those injuries, for though Tennessee is a "determination" state, it retains the right to make its own eligibility assessments (as well as the obligation to ensure that these determinations are done in a reasonably prompt

manner). Thus Plaintiffs have standing to sue Defendants. For the same reason, the federal government is not a necessary party to this action, since Defendants may fully redress Plaintiffs, and because Defendants face no credible risk of being subject to inconsistent obligations. Finally, there is no "unusual circumstances" exception that could usurp Defendants' obligation to ensure a timely determination.

Plaintiffs, and the class they seek to represent, will also suffer irreparable harm. This is true as a matter of law given that the class is comprised of low-income individuals who are going without necessary medical coverage, and is not resolved by the State's proposed hospital presumptive eligibility plan. The public interest is also served by the injunction sought by Plaintiffs, and the risks and fears raised by Defendants do not stand up to serious scrutiny.

Finally, the proposed order submitted by Plaintiffs is reasonably calculated to remedy the harms presented in this action.

I. PLAINTIFFS ARE LIKELY TO SUCCEED ON THE MERITS.

A. Plaintiffs' Rights to a Prompt Determination and Fair Hearing are Enforceable under Section 1983.

1. Plaintiffs' right to a prompt determination under § 1396a(a)(8) is enforceable.

Plaintiffs' right to a prompt determination under 42 U.S.C. § 1396a(a)(8) is enforceable. Every State Plan must provide individuals with the right to apply for Medicaid benefits and to a determination of eligibility and provision of benefits for eligible individuals "with reasonable promptness." 42 U.S.C. § 1396a(a)(8). As stated by the Sixth Circuit, this provision is most reasonably interpreted to both mean that "all eligible individuals should have the opportunity to apply for medical assistance," and that this assistance "shall be provided to the individual with reasonable promptness." *Westside Mothers v. Olszewski*, 454 F.3d 532, 540 (6th Cir. 2006) ("*Westside Mothers II*"). Defendants cite an unpublished Sixth Circuit decision and district court

decision from over 20 years ago, but the Sixth Circuit has since held that this provision is enforceable under section 1983, as have all district courts in this circuit since that opinion. *See Westside Mothers v. Haveman*, 289 F.3d 852, 863 (6th Cir. 2002) ("*Westside Mothers I*"); *see also Westside Mothers v. Olszewski*, 368 F. Supp. 2d 740, 757–63 (E.D. Mich. 2005), *aff'd in part, modified in part and rev'd in part*, 454 F.3d 532 (6th Cir. 2006); *Crawley v. Ahmed*, No. 08-14040, 2009 WL 1384147, at *16-19 (E.D. Mich. May 14, 2009); *Ability Ctr. of Greater Toledo v. Lumpkin*, 808 F. Supp. 2d 1003, 1019–22 (N.D. Ohio 2011). Other circuit courts hold the same. *See Romano v. Greenstein*, 721 F.3d 373, 377–79 (5th Cir. 2013); *Sabree v. Richman*, 367 F.3d 180, 190–92 (3d Cir. 2004); *Bryson v. Shumway*, 308 F.3d 79, 88–89 (1st Cir. 2002); *Doe v. Chiles*, 136 F.3d 709, 715–19 (11th Cir. 1998).

Defendants' reliance on *Rosie D. v. Romney*, 410 F. Supp. 18 (D. Mass 2006), is also misplaced. *Rosie D.* did not involve *eligibility*, but rather the "reasonably prompt" provision of *medical services*, *id*. at 22, which is governed by 42 C.F.R. § 441.56(e), not § 435.912. *See id*. at 27. Those regulations establish only an "outer limit of 6 months" to provide reasonably prompt treatment after a request, and timeliness in that context clearly depends on the nature of the services sought. *Id*. Nevertheless, that court certified the class and issued permanent injunctive relief because Defendants failed to provide services with reasonable promptness. *Id*. at 22, 55.

The regulations implementing section 1396a(a)(8) further refine and effectuate this right. These regulations require states to set standards for timeliness regarding the "maximum period of time in which every applicant is entitled to a determination of eligibility" that may not exceed 45 days for most categories of eligibility and 90 days if based on disability. 42 C.F.R. § 435.912(a)(1), (c)(3). A regulation "may be enforced via the private cause of action available under that statute" "if the regulation simply effectuates the express mandates of the controlling

statute." *Ability Ctr. of Greater Toledo v. City of Sandusky*, 385 F.3d 901, 906 (6th Cir. 2004) (citing *Alexander v. Sandoval*, 532 U.S. 275, 284 (2001)); *see also Harris v. Olszewski*, 442 F.3d 456, 465 (6th Cir. 2006). Courts have interpreted these regulations as effectuating the mandate of section 1396a(a)(8) and have relied on them to define the scope of reasonable promptness. *See Westside Mothers II*, 454 F.3d at 540–41 ("The regulations that implement these provisions also indicate that what is required is a prompt determination of eligibility and a prompt payment to eligible individuals to enable them to obtain the necessary medical services.") (citing 42 C.F.R. §§ 435.911[6]; 435.930); *Ability Ctr. of Greater Toledo*, 808 F. Supp. 2d at 1020 (defining "reasonable promptness" by reference to 42 C.F.R. §§ 435.911; 435.930 and finding the requirements of § 435.911 privately enforceable); *see also Romano*, 721 F.3d at 379 & n.35; *Doe v. Chiles*, 136 F.3d at 717.

Defendants' duty to provide medical services with "reasonable promptness" is not "so vague and amorphous as to defeat judicial enforcement." *Westside Mothers I*, 289 F.3d at 863 (discussing § 1396a(a)(8)); s*ee also Romano*, 721 F.3d at 379; *Martin v. Taft*, 222 F. Supp. 2d 940, 978 (S.D. Ohio 2002). This provision, in combination with the implementing regulations, clearly sets out what is required—a prompt determination within 45 days for most applicants or 90 days for those whose application is based on disability—and the opportunity for a hearing when these requirements are not met. *See Romano*, 721 F.3d at 378–79 (quoting *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990)). Moreover, Defendants are incorrect that the statutory reference to "reasonable" renders this provision too vague to enforce, as courts "have reviewed actions for reasonableness since time immemorial." *Bryson v. Shumway*, 308 F.3d 79,

[6] The regulations defining reasonable promptness have been redesignated from 42 C.F.R. § 435.911 to § 435.912 after the implementation of the Affordable Care Act. *See* Eligibility Changes under the ACA, 77 Fed. Reg. 17144-01, at 17161**,** 17209 (Mar. 23, 2012).

89 (1st Cir. 2002) (discussing § 1396a(a)(8) and citing 1 W. Blackstone, *Commentaries* *77).

2. Plaintiffs' right to a fair hearing under § 1396a(a)(3) is enforceable.

Plaintiffs' right to a fair hearing under 42 U.S.C. § 1396a(a)(3) is also enforceable. The Medicaid Act requires state programs to "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." 42 U.S.C. § 1396a(a)(3). This statutory provision clearly provides rights "to any individual," and the Sixth Circuit has held that it is enforceable under § 1983. *Gean v. Hattaway*, 330 F.3d 758, 772 (6th Cir. 2003); *see also Shakhnes v. Berlin*, 689 F.3d 244, 250–51 (2d Cir. 2012), *cert. denied*, 133 S Ct. 1808 (2013); *D.W. v. Walker*, No. 2:09–cv–00060, 2009 WL 1393818, at *5 (S.D. W.Va. 2009); *McCartney v. Cansler*, 608 F. Supp. 2d 694, 699 (E.D.N.C. 2009). As explained above, the concept of "reasonable promptness" is defined in the regulations and is not too vague to defeat judicial enforcement, and, in any event, one of the statutory bases for the hearing content is whether action on the application has been delayed for an unreasonable time. *See* 42 U.S.C. § 1396a(a)(3); 42 C.F.R. § 431.241(a).

Moreover, this right to a fair hearing is also guaranteed by the Due Process Clause, which is enforceable under section 1983. *See Hamby v. Neel*, 368 F.3d 549, 559–60 (6th Cir. 2004) (Due Process Clause requires appropriate notice and hearing). In *Hamby*, the Sixth Circuit held that applicants had a property interest in TennCare that triggered due process rights when their application was denied. *Id.* As Defendants have noted, "due process is flexible and calls for such procedural protections as the particular situation demands." *Morrissey v. Brewer,* 408 U.S. 471, 481 (1972). Plaintiffs have effectively been denied services by TennCare for many months while their eligibility has not been determined, and thus are entitled to a hearing. Due process

will not allow Defendants to skirt their obligations by indefinitely delaying application decisions and, in the meantime, failing to provide services to those applicants.

B. Defendants are Responsible for Ensuring Plaintiffs' Rights to Prompt Determinations and Fair Hearings.

The Medicaid Act makes clear that, once a state elects to participate in Medicaid, it must designate "a single State agency to administer or to supervise the administration of the plan . . . ." 42 U.S.C. § 1396a(a)(5). That State agency—here, the Tennessee Department of Finance and Administration (DFA)—"may not delegate, to other than its own officials, the authority to supervise the plan." 42 C.F.R. § 431.10(e). This requirement has long been a part of the federal Medicaid law, and does not allow the single State agency to escape liability for its duties under the Medicaid Act by delegating some tasks to other entities. *See Linton v. Commissioner*, 779 F. Supp. 925, 936 (M.D. Tenn. 1990), *aff'd on other grounds*, 65 F3d 508 (6th Cir. 1995) (duty to certify nursing home participation in Medicaid non-delegable); *Carr v. Wilson-Coker*, 203 F.R.D. 66, 75 (D. Conn. 2001) (§ 1396a(a)(8) non-delegable) (citing 42 U.S.C. § 1396a(a)(5); 42 C.F.R. § 431.10; *Catanzano v. Dowling*, 60 F.3d 113, 118 (2d Cir. 1995)); *McCartney ex rel. McCartney v. Cansler*, 608 F. Supp. 2d 694, 701 (E.D.N.C. 2009) (providing fair hearing non-delegable), *aff'd sub nom. D.T.M. ex rel. McCartney v. Cansler*, 382 F. App'x 334 (4th Cir. 2010); *J.K. ex. rel. R.K. v. Dillenberg*, 836 F. Supp. 694, 699 (D. Ariz. 1993).

Defendants argue that Congress implicitly revoked these statutory obligations by passing the ACA, claiming they now retain no responsibility for complying with the fair hearing and reasonably prompt determination requirements of the Medicaid Act because they refused to create their own state Exchange. They also argue that, because no regulation *requires* the FFM to provide pending application files to the State, "the ACA does not contemplate any State actions while an unresolved application is pending with the FFM." Defs.' Opp. to Mot. for Prelim. Inj.

("DOMPI") 22 (ECF No. 59). But these arguments are directly contrary to the ACA, which states that, "[n]othing in this title . . . shall be construed to modify any existing Federal requirement concerning the State agency responsible for determining eligibility for [programs including Medicaid]." 42 U.S.C. § 18118.

Defendants do cite 42 U.S.C. § 18041(c)(1), *see* DOMPI 21, yet that statute only establishes that a federal exchange will exist—it does not relieve the single State agency of its obligation to oversee its program under 42 U.S.C. § 1396a(a)(5). Defendants cite 42 U.S.C. § 18083(a) & (b)(1)(A)(iii), DOMPI 21, but these sections address only the requirement that a process be in place to transfer eligible applicants from the federal Marketplace to state Medicaid programs like TennCare. The federal Marketplace thus plays a role, but the ACA did not ordain CMS as the chief czar of all eligibility determinations for all state programs.

Defendants also assert that since they elected to be a "determination" state for MAGI determinations, their failings should be excused. Again, the significance of their decision is dramatically overstated. Defendants emphasize 42 C.F.R. § 431.10(c)(1) which authorizes delegation of Medicaid eligibility determinations to the FFM, but they do not address the provisions of the same regulation that require the "single State agency" to ensure that all federal laws are followed notwithstanding that delegation. § 431.10(c)(3); *see also* § 435.1200(b)(3)(iii) & § 435.1200(c)(3). The regulation further admonishes that it is [t]he single State agency [that] is responsible for determining eligibility for all individuals applying for or receiving benefits . . . and for fair hearings filed . . .," § 431.10(b)(3), and it instructs the single State agency to take appropriate measures if federal laws are not being followed, ensuring that it is the single State agency that remains in charge. § 431.10(c)(3). *See also K.C. ex rel. Africa H. v. Shipman*, 716 F.3d 107, 119 (4th Cir. 2013).(noting that "[o]ne head chef in the Medicaid kitchen is enough").

Thus TennCare may not be able to dictate how the FFM (or other third parties) operate, but it is responsible for what is within its control—ensuring a determination of an applicant's eligibility is made when the system it has have elected to use is not functioning as expected.

The relief that Plaintiffs seek does not require Defendants to obtain applications from the FFM—it simply requires them to establish a system to comply with their requirements under the Medicaid Act. Defendants have chosen to give determination authority, rather than assessment authority only, to the FFM, but nothing prevents the State from making its own determination of eligibility on a particular application—which the FFM must honor. *See* 45 C.F.R. §§ 155.302(b)(5); 155.345(h); Fair Hearings and Appeal Processes, 78 Fed. Reg. 42160, 42167–68 (July 15, 2013).

Plaintiffs do not seek to hold Defendants responsible for the Exchange, DOMPI 21, 23, but rather for the State's own responsibilities under the Medicaid Act. Through regulations and other communications, CMS—the very entity on which Defendants attempt to pin responsibility—has already advised Defendants that they remain responsible for securing Plaintiffs' rights even when delegation occurs to the Federal exchange. *See* §§ 431.10; 435.1200; Letter from Cindy Mann to Darin Gordon 1, 2 (Brooke Decl. ex. 14) (noting that Tennessee is not meeting critical success factors, including ability to accept a single, streamlined application, ability to process applications based on MAGI rules, and offering assistance and examples of mitigation approaches used by other states); Exchanges: Eligibility and Enrollment, 78 Fed. Reg. 42160-01, 42165 (July 15, 2013) ("[B]oth state Medicaid agencies and the Exchange have distinct responsibilities to provide for such hearings, and we do not have authority to eliminate individuals' statutory rights, or a Medicaid agency's or Exchange's statutory responsibility."); *id.* at 42164 ("[T]he statute requires that the option [to have a hearing before the State] be

provided."); Eligibility Changes Under the ACA, 77 Fed. Reg. 17144-01, 17188 (Mar. 23, 2012) ("As is true whenever a single State agency delegates authority to another entity to make eligibility determinations, we continue to require that the single State agency must supervise the administration of the plan, is responsible for making the rules and regulations for administering the plan, and is accountable for the proper administration of the program."). Thus even if the federal Marketplace is the cause of some of the delay, it remains the State's ultimate responsibility for providing determinations promptly, which has long been a requirement and feature of the state-federal interaction in the Medicaid system. *See* 42 C.F.R. § 435.541(c)(2), (3) (requiring the state Medicaid agency to make determinations of disability even if the SSA has not acted within the 90 day time limit for determining eligibility for Medicaid).

Moreover, even according to Defendants' own assertions, Defendants are able to obtain individualized case files from CMS for those who applied to the FFM if they wish to utilize this method to comply with their prompt determination requirements. *See* Hagan Decl. ¶¶ 12–13. Defendants and their agent, the Tennessee Health Connection, already initiate calls with the FFM to obtain additional information about applicants' pending applications. *See* Hagan Decl. ¶¶ 5, 7; J.P. Decl. ¶ 6. Other options would also be available, including self-attestations. 42 C.F.R. § 435.945. In summary, the Medicaid Act requires Defendants to organize their application process in a way that provides prompt determinations and services to Plaintiffs—and Plaintiffs seek relief from this Court that will require them to provide these determinations.

C. Plaintiffs Have Standing to Sue Because Defendants Have Caused, and Can Redress, Plaintiffs' Injuries.

For the reasons described above, Defendants' standing arguments based on causation and redressability must also fail. Plaintiffs have alleged that the action and inaction of the State—in failing to create a process by which applicants can obtain a prompt determination and in failing

to provide a fair hearing when determinations are overdue—have caused their injuries. Even if the FFM has its own independent legal obligations to the Plaintiffs or Defendants to adjudicate applications in a timely manner, this does not abrogate Defendants' own duty to do so or absolve Defendants of any inquiry into their own liability. "[T]he causation requirement in standing is not focused on whether the defendant 'caused' the plaintiff's injury in the liability sense; the plaintiff need only allege 'injury that fairly can be traced to the challenged action of the defendant, and not injury that results from the independent action of some third party not before the court.'" *Wuliger v. Manufacturers Life Ins. Co.*, 567 F.3d 787, 796 (6th Cir. 2009) (quoting *Simon v. E. Ky. Welfare Rights Org.*, 426 U.S. 26, 41–42 (1976)). As explained above, Plaintiffs' injuries can be traced to Defendants' refusal to ensure timely adjudications, and refusal to ensure a fair hearing, and their correlated decisions to send almost all applicants to the FFM and to eliminate the role of DHS in providing eligibility determinations and eliminating the staff that worked in this role, and Defendants' inaction when decisions have not been made promptly. Thus, the FFM's role in determining eligibility, and any problems that result, are not due solely to "independent action of some third party." *Id.* The relief that Plaintiffs have requested is a prompt eligibility determination after they have waited often more than three or four times longer than the time specified by federal law, and the ability to have a hearing when applications are delayed. If Defendants are ordered by the Court to provide this relief, it will redress Plaintiffs' ongoing injuries. Furthermore, Defendants have shown they are capable of enrolling Plaintiffs into TennCare; as such they are capable of providing adequate redress.

Finally, even if for some reason Defendants are not responsible for some subset of individuals who are sent to the FFM—which Plaintiffs' dispute as detailed above—there can be no argument that they are responsible for providing a prompt determination and a hearing for

applicants who do not involve a MAGI determination and therefore are not being processed through the FFM, which includes CHOICES or MSP applicants who are also facing substantial delays. *See supra* pp. 5–8.

D. The Federal Government is not a Necessary Party Under Rule 19.

Defendants also contend the federal government is a necessary party under Rule 19 of the Federal Rules of Civil Procedure. *See Glancy v. Taubman Centers, Inc.*, 373 F.3d 656, 666 (6th Cir. 2004) (describing three-part test of whether the party is necessity, whether joinder would deprive court of jurisdiction, and whether the absent party is indispensable). A party is "necessary" if, "in that person's absence, the court cannot accord complete relief among existing parties;" or "that person claims an interest relating to the subject of the action and is so situated that disposing of the action in the person's absence may: (i) as a practical matter impair or impede the person's ability to protect the interest; or (ii) leave an existing party subject to a substantial risk of incurring double, multiple, or otherwise inconsistent obligations because of the interest." Fed. R. Civ. P. 19(a). By contrast, a joint tortfeasor is never a necessary party under Rule 19. *Temple v. Synthes Corp., Ltd.*, 498 U.S. 5, 7 (1990) (per curiam).

The federal government is not a necessary party to this action. Defendants' liability in this matter flows not through actions by the federal government, but through their own failings, as the single State agency, to ensure prompt determinations under section 1396a(a)(8), and hearings under (a)(3) and the Due Process Clause. The Court may provide full relief to Plaintiffs, and resolve all disputes between the Parties in this action, by requiring Defendants to provide a hearing and to adjudicate the applications of those who have been pending for more than 45 or 90 days.

Defendants suggest the FFM is necessary since it is the repository of non-complete application files, but as explained above, TennCare does not need the FFM's files in order to

accord full relief. Though Tennessee is a determination state, it still retains the full authority to make its own eligibility assessments, which the FFM must respect. 45 C.F.R. §§ 155.302(b)(5); 155.345(h); Fair Hearings and Appeal Processes, 78 Fed. Reg. 42160, 42167–68 (July 15, 2013). Furthermore, a fair hearing permits the introduction of evidence by the applicant, 42 C.F.R. § 431.242(b)–(e), and permits a *de novo* determination, § 431.242(a), .244(a)–(b); *see also Curtis v. Roob*, 891 N.E.2d 577, 580–81 (Ind. Ct. App. 2008). The outcome of this process could be a determination that the eligibility determination had not been completed reasonably promptly, § 431.241(a), and an order requiring other corrective action if the applicant prevailed. § 431.246. Thus the FFM is not necessary for relief to be granted to Plaintiffs.

The federal government also does not have any particular interest in the outcome of the dispute between Plaintiffs and TennCare. As noted above, Tennessee retains the full authority to make its own eligibility assessments, which determinations the FFM must respect, and thus the FFM does not have an "interest" it must protect in this litigation.

Finally, there is no "substantial risk" that Defendants will find themselves subject to inconsistent obligations. Plaintiffs seek to hold Defendants accountable to their obligations under federal law to provide a hearing and promptly adjudicate applications that have been pending beyond the time limits contained in CMS's own regulations. The Mitigation Plan Process was implemented for states "that were anticipating not being in full compliance with the rules and procedures relating to these core areas." Ltr. from Mann to Gordon 1 (June 27, 2014) (Ex. 14 to Brooke Decl., ECF No. 4-1 at 123–25 of 125). If this Court were to hold Defendants responsible for providing hearings and determinations—their duty under the Medicaid Act—there is no risk that the mitigation process would result in an order prohibiting the State from providing hearings or determining applicants' eligibility. *See* 45 C.F.R. §§ 155.302(b)(5) and 155.345(h) (FFM must

respect eligibility determinations of State); 42 C.F.R. § 431.250(b)(2), (d) (providing federal matching funds for payments made "for services provided within the scope of the Federal Medicaid program and made under a court order" and "to extend the benefit of a . . . court order to individuals in the same situation as those directly affected by the decision or order"). *See also PRI, Inc. v. Keith*, No. 11-4157-NKL, 2011 WL 6402281, at *2 (W.D. Mo. Dec. 21, 2011) ("That claim does not raise any possibility that Defendants will be subject to inconsistent obligations—one requiring it to provide a hearing and another prohibiting a hearing."). Furthermore, what CMS has already suggested Defendants do is entirely consistent with the relief sought in this case—provide a means for persons who are struggling to get enrolled a method to do so. *See* Ltr. from Mann to Gordon 2-3 (June 27, 2014) (discussing mitigation options).[7] Defendants, by contrast, have identified no inconsistent obligations that they may face if CMS approved their current proposed mitigation plan or suggested alternatives, and cannot avoid potentially more onerous relief through this case by making generalized assertions about the mitigation process.

[7] The cases cited by Defendants find joinder necessary for third parties that have either already provided defendants with a directly conflicting order or are in the process of doing so. In *Bridges v. Blue Cross & Blue Shield Association*, 889 F. Supp. 502 (D.D.C. 1995), the Office of Personnel Management (OPM) was actively negotiating "an agreement which would provide rebates to some federal employees"—the precise relief that plaintiffs (federal employees) were seeking in the lawsuit. *Id.* at 504. While there was a substantial likelihood that the court and OPM would come to different conclusions about the amount of money to be paid to plaintiffs, no such danger is present here. The additional cases are similarly inapposite. *See Weeks v. Hous. Auth. of City of Opp, Ala.*, 292 F.R.D. 689, 691, 693 (M.D. Ala. 2013) (finding HUD was a necessary party because of HUD's "express directive" not to compensate Plaintiff and HUD's freezing of Defendant's bank account in order to prevent this compensation); *Idaho Aids Found., Inc. v. Idaho Hous. & Fin. Ass'n*, 422 F. Supp. 2d 1193, 1208 (D. Idaho 2006) (finding, after originally rejecting joinder of HUD, that joinder was now necessary in light of the record developed and factual findings that Defendant's actions "were solely in response to HUD's orders").

E. Defendants Are Not Excused From Making Determinations with Reasonable Promptness Because of Unusual Circumstances.

Defendants do not dispute that Plaintiffs and putative class members are beyond the 45 and 90 day time periods that constitute reasonable promptness under 42 U.S.C. § 1396a(a)(8) or 42 C.F.R. 435.912(c)(3). They try to excuse their malfeasance, however, by arguing that that the FFM itself constitutes an "unusual circumstance" that excuses their delay. *See* 42 C.F.R. § 435.912(e); DOMPI 29-31. This argument is meritless.

Section 435.912(e) does excuse the single State agency's compliance with the normal 45 or 90 day rule when there is an "unusual circumstance" such as "[w]hen there is an administrative or other emergency beyond the agency's control." *Id.* Moreover, by its plain text, this exception can only apply when the circumstance is "unusual," it is an "emergency," and it is "beyond the agency's control." *Id.* By now—August of 2014, ten months since the initial rollout of the Affordable Care Act—none of these criterion can credibly be claimed by Tennessee. To the contrary, the delays many applicants are suffering have become the new normal, and they are the result of the continued status quo of TennCare to not create any process to ensure that individuals facing delays could receive meaningful assistance. Tellingly, Defendants' listing of unusual circumstances, DOMPI 16–17; Defs.' Br. in Opp. to Class Cert. 9–10, involves the activities of day-to-day operation of a Medicaid program—verifying income, citizenship and residency—activities that TennCare employees have successfully engaged in for decades. Those activities are not "unusual circumstances" within the meaning of the federal regulation and, thus, do not excuse the Defendants' across-the-board refusal to make eligibility decisions for those Tennesseans who are stuck for months without a decision on their Medicaid application.

Defendants point to correspondence between Pennsylvania's state Medicaid system and CMS, but this correspondence is distinguishable from Tennessee's current circumstance, and

certainly does not establish that the "reasonable promptness" requirements may be disregarded. Pennsylvania requested relief for a limited period of time (until March 31, 2014) during the middle of open enrollment (from October 1, 2013, to March 31, 2014), during which time there was an increased spike in applications, and during which time the FFM faced its biggest bureaucratic challenges. Pennsylvania noted in its letter that it was facing specific problems relating to the early delays with the FFM account transfers. Importantly, Pennsylvania noted that there were a large number of duplicate applications because of delays in transfers from the FFM.

Tennessee, on the other hand, has no duplicate applications, as it has refused to implement any process by which Tennessee will accept and determine eligibility. CMS has not blessed Tennessee's actions in any way that should be given "substantial deference" (DOMPI 31)[8]; in fact, CMS has criticized Tennessee's actions. *See* Ltr. from Mann to Gordon 2 (June 24, 2014) (ECF No. 124 of 125) ("[W]e have also repeatedly shared our concerns about the lack of an in-state mitigation plan that would allow people to apply for coverage based on MAGI rules directly to the Tennessee Medicaid agency. . . . In light of the continued slippage in TEDS implementation and the state's ongoing responsibilities under the law, it is essential for Tennessee to move forward with workable mitigations. The Federal approval to leverage the FFM to receive and process applications on the state's behalf was approved as a short-term measure, not a long-term solution."). CMS has even proposed manual processing and hiring additional staff to help with this endeavor, and offered enhanced Medicaid matching funds. *Id.*

Perhaps an argument could be made that in the initial days, weeks, and even months of

[8] To the extent the Court places any weight on this letter, it should not be afforded any deference, but rather may only be "entitled to respect under *Skidmore v. Swift & Co.*, 323 U.S. 134, 140 (1944) only to the extent that those interpretations have the power to persuade." *Hughes v. McCarthy*, 734 F.3d 473, 478 (6th Cir. 2013) (internal quotations and citations omitted), cert. denied, 134 S. Ct. 1765 (U.S. 2014).

the rollout of the FFM and the initial implementation of the ACA, certain "unusual" "emergency" circumstances may have existed. Yet as time has passed, so too has any claim that these circumstances remain "unusual," or that an "emergency" is still overwhelming TennCare. Rather, as CMS has made clear, while other states have adopted strategies and solutions to minimize delays faced by their citizens, Tennessee has not. It may not now use its own recalcitrance to claim that it is acting "reasonably promptly" to adjudicate delayed applications, when in fact it is doing nothing at all, save waiting for these applications to work themselves through the FFM.

And of course, Defendants' contention regarding "unusual circumstances" carries especially little weight for the non-MAGI eligible applicants, like CHOICES and MSP applicants who have also been facing significant delays in violation of Section 435.912(c)(2). *See supra* pp. 5–8. There can be no argument that the delays suffered by these individuals can be excused by that which occurred at the FFM.

II. PLAINTIFFS WILL SUFFER IRREPARABLE HARM IN THE ABSENCE OF IMMEDIATE RELIEF.

Defendants next argue that Plaintiffs have not established irreparable harm for themselves or for the class. Defendants first argue that since they have enrolled Plaintiffs in TennCare,[9] these Plaintiffs' claims are moot. They further argue that there is no evidence of classwide irreparable injury. They also suggest that any irreparable harm has already been remedied by new plans they have started to, or plan in the future, to implement. These arguments are without merit.

[9] Defendants' briefing refers to nine of eleven being enrolled. Since that time the remaining two—T.V. and D.A.—have been enrolled.

A. The Named Plaintiffs May Represent the Class Even If Their Claims are Moot.

As explained more fully in Plaintiffs' Reply in Support of Class Certification, there is a well-recognized exception to mootness in the context where class certification has been diligently pursued, and Defendants have "picked off" the named Plaintiffs, precisely because Defendants should not be able to "opt out" of a class action lawsuit by simply providing relief to the named representatives. *See* Pls.' Reply in Supp. of Class. Cert. 16–20; *Carroll v. United Compucred Collections, Inc.*, 399 F.3d 620, 625 (6th Cir. 2005). In that scenario Plaintiffs' claims are considered to relate back to the time of filing so as to avoid a determination of mootness. *Id.*; *see also Weiss v. Regal Collections*, 385 F.3d 337, 349 (3d Cir. 2004) ("unilateral action by the Defendant rendered the plaintiffs' claims 'inherently transitory'"); *id.*at 346–49 (discussing relating back). Thus to the extent Plaintiffs' claims are considered moot, they should be considered as relating back to the filing of the complaint, and thus an exception to the mootness doctrine.

B. The Entire Class is Suffering Irreparable Harm.

As explained in Plaintiffs' Memorandum in Support of Preliminary Injunction, case law is replete with examples of decisions finding that "[g]iven the often perilous economic circumstances of the plaintiffs [being denied Medicaid and Food Stamp benefits], and those similarly situated, the denial of public benefits to such individuals unquestionably constitutes irreparable harm." *M.K.B. v. Eggleston*, 445 F. Supp. 2d 400, 437 (S.D.N.Y. 2006); *see also* Pls.' Mem. in Supp. of Prelim. Inj. 16–18 (collecting cases). Rather than address any of the cited cases, Defendants instead cite to a single case, *Bruns v. Mayhew*, 931 F. Supp. 2d 260 (D. Me. 2014), *affirmed on other grounds*, 750 F.3d 61 (1st Cir. 2014). *Bruns* is inapposite.

Bruns involved a challenge by two individuals on equal protection grounds to a decision

by Maine's legislature to discontinue state-funded benefits to certain qualified aliens. 931 F. Supp. 2d at 263. The district court found that the plaintiffs had no likelihood of prevailing on the merits of their equal protection claim, but nevertheless elected to address the irreparable harm issues "for the sake of completeness." *Id.* at 273. In considering irreparable harm, the district court recognized that while in general "'[t]he wrongful denial of governmental benefits may constitute irreparable injury,'" in that case there was no wrongful denial since the plaintiffs were not likely to prevail on the merits, and thus no presumption of irreparable injury. *Id.* at 274 n.8 (alterations in original, quoting *Maine Assoc. of Ind. Neighborhoods v. Petit* 647 F. Supp. 1312, 1315 (D. Me. 1986)). The district court further noted that the case involved only two named plaintiffs, and for one of them no actual evidence of her circumstances (such as a declaration) was presented to the court. *Id.* at 275. The district court thus found there was insufficient evidence to show classwide risk of irreparable harm that would justify injunctive relief. *Id.* at 276. Appeal was taken, and the decision was affirmed on the "likelihood of success" prong alone, without reaching the issue of irreparable harm. 750 F.3d 61, 65 (1st Cir. 2014).

By contrast, in this case there is declaratory evidence regarding each of the eleven named plaintiffs, and putative class members who are not named Plaintiffs have suffered similar harms. *See supra* pp. 8–10.

And most significantly, as noted above and in Plaintiffs opening brief, the vast majority of cases readily recognize that for Medicaid applicants, delays or denials necessarily cause irreparable harm. *See Merkner v. AK Steel Corp.*, 1:09-CV-423, 2010 WL 373998 at *5 (S.D. Ohio Jan. 29, 2010 (finding that increases in out-of-pocket expenses for medical coverage would result in "decrease in medical care, the rationing of other necessities of life, and an increased uncertainty and anxiety . . . .").

C. The State's Potential Hospital Presumptive Eligibility SPA Does Not Presently, and Likely Will Never Eliminate the Risk of Irreparable Harm to Class Members.

The State relies heavily on its assertion that it intends to implement a hospital presumptive eligibility (HPE) program "that will enable hospitals to grant presumptive eligibility to any qualifying individual for a 45-day period of time while that individual applies for Medicaid." DOMPI 3, 10, 29, 32, & 38. The State was required to implement this requirement by January 1, 2014, with the State Plan Amendment ("SPA") filed by end of that quarter, 42 C.F.R. §435.111; CMS, Implementing Hospital Presumptive Eligibility Programs 2 (Jan. 2014) (attached as Ex. 3 to Zampierin Decl.); instead, the State submitted it on July 14, and it is not yet approved.

The State has designed its HPE proposal in a manner that makes its supposed protections illusory. First, HPE would not be available to many especially vulnerable groups of TennCare applicants. States are required to accept only hospital presumptive eligibility determinations for pregnant women, children, their caretaker relatives, former foster care children, and individuals needing treatment for breast or cervical cancer. 42 C.F.R. § 435.1110(c). Tennessee has not proposed to cover any additional groups. Ltr. from Gordon to Mann (July 14, 2014) & SPA (ECF No. 4-1 at 58–64 of 125).

Moreover, the State's proposed HPE program does not comply with federal law, and is therefore unlikely to receive federal approval. The regulations apply the definition of "period of presumptive eligibility" that applies to presumptive eligibility for children and pregnant women, 42 C.F.R. §435.1110(a), which is defined to ensure that if a person enrolled through presumptive eligibility files an application by the last day of the month following her enrollment, she is assured of coverage pending a decision on that application, and protected from any possible delay in adjudication. *See* 42 C.F.R. § 1101. The State's SPA deviates from the law by providing

that the presumptive eligibility period ends automatically after 45 days. (ECF No. 4-1 at 59 & 63 of 125.) Moreover, the State conditions implementation of the proposal on the right to terminate coverage without determining whether the person is eligible for coverage, and without notice and an opportunity to appeal, in violation of longstanding constitutional, statutory and regulatory due process requirements. *Id.*; *cf.* 42 U.S.C §1396a(a)(3); 42 C.F.R. § 435.913; *Goldberg v. Kelly*, 397 U.S. 254 (1970); *Rosen v. Goetz*, 410 F.3d 919 (6th Cir. 2005).

Even if it were approved, few if any hospitals would elect to participate. The federal regulations permit states to impose standards that hospitals must meet in order to qualify to make presumptive eligibility determinations. 42 C.F.R. §435.1110(d)(1); Medicaid and Children's Health Ins. Pgms., 78 Fed. Reg. 42160-01, 42176 (July 15, 2013). The Tennessee proposal would require any participating hospital to ensure that:

> 100% of all individuals determined to be presumptively eligible must complete a regular application within five (5) calendar days of the beginning of the presumptive eligibility period. Additionally, 100% must submit all requested verification documents and otherwise respond to requests for additional information within five (5) calendar days of receipt of said requests. Thus, a hospital faces termination of HPE privileges if any applicant that they made presumptively eligible does not follow through and fully complete the Medicaid application process within the prescribed timeframes.

(ECF No. 4-1 at 62 of 125.) This "zero tolerance" requirement on completing applications would be impossible for any hospital to meet. A hospital could be expected to assist most of its HPE enrollees to complete regular Medicaid applications within five days. But completion of regular applications would be impossible for many due to their medical condition, or because of the need to submit documentation that would require more time to compile. Furthermore, the second requirement of responding to request for additional information within five days would be impossible as well. That request for more information or documentation could come weeks or

months after submission of the original application.[10] In many cases this would be long after the applicant's contact with the hospital has ended, when the hospital has no way to know that the applicant has even received such a request, much less ensure that the applicant responds within the five days the Defendants demand.

Finally, the SPA is not yet approved, and could not be implemented for months if it ever is approved by CMS. (*See* ECF No. 4-1 at 60 of 125 (noting steps to be taken after approval of SPA)). This "plan" therefore has no bearing on Plaintiffs or the Class at this time. *See Pashby v. Delia*, 709 F.3d 307, 316–17 (4th Cir. 2013). If CMS gives approval to this request, if it is implemented, and if Plaintiffs would no longer be subject to irreparable harm, Defendants may then move to dissolve any preliminary injunction ordered by this Court. *See Stratienko, M.D. v. Chattanooga-Hamilton Cnty. Hosp. Auth.*, No. 1:07-CV-258, 2008 WL 4191275 (E.D. Tenn. Sept. 8, 2008).

III. THE PUBLIC INTEREST IS SERVED BY GRANTING THE RELIEF PLAINTIFFS SEEK.

Defendants finally create a parade of horrors to try to explain why helping people receive a determination on their Medicaid applications, or to provide a hearing when determinations are delayed—both of which Defendants are legally required to do—is against the public interest. The concerns raised do not stand up to examination.

First, Defendants contend that the current system is "working well for the vast majority of applicants." Of course Plaintiffs do not take issue with the ability of any applicant who is able to get through the current system. Plaintiffs' sole concern is with the "small percentage" of applicants for whom the current system is *not* working well. DOMPI 14.

Second, Defendants appear to fear that tens of thousands of individuals will abandon the

[10] *See, e.g.*, Reynolds Decl. ¶ 5; J.F. Decl. ¶ 12.

current system and instead try to utilize the injunctive relief requested by Plaintiffs. *See* DOMPI 42; Long Decl. ¶ 10. These fears defy common sense. First, the relief sought by Plaintiffs would apply to individuals who have been waiting for over 45 or 90 days only; Plaintiffs are not asking the Court to order TennCare to start processing all new applications in this manner, nor to create a "new door." Second, the near-exclusive method for the public to interact with TennCare is through its call center, the Tennessee Health Connection ("TNHC")—the same location applicants who have any question about their application (including why it is not yet adjudicated) are calling. Thus anyone who hypothetically might call TNHC thinking that there is a newer, more expeditious way to apply would be told the same thing TNHC is telling everyone else—if the individual is starting from scratch, her or his option is to apply online or by calling the FFM. The only people who would be "diverted" are those for whom the process is *not* working—those who have not received a reasonably prompt determination.

Third, Defendants also fear that backlogs will plague the TennCare system. *See* DOMPI 42–43; Long Decl. ¶ 10. Again, this argument defies common sense. At present Tennessee has no backlog, *not* because their system is working perfectly, but because they are simply *ignoring* the problems they have. For example, the State knows that, of 200 problem cases brought to their attention by advocates, they have worked through only a "majority" of those cases. Hagan Decl. ¶¶ 6–7. Yet the cases still outstanding are not part of a "backlog" because Tennessee has refused to create any log at all. Put differently, the concern over a backlog misses the fundamental point that if any backlog is created by the injunction, it will consist solely of persons who the current system is already failing—persons whose applications have been pending beyond the period authorized by federal law. For those who are having delays without explanation, it surely will be a welcome relief that he or she is at least now on a list.

Furthermore, Defendants themselves suggest that the backlogs in other states were being caused by the failure of those states to have an automated system to receive account transfers from the FFM. DOMPI 15; Long Decl. ¶ 3(a) (comparing TennCare "in sharp contrast to other states that we understand have large backlogs because they have not been able to load individuals from either the flat files or the H15 Account Transfers."). Since the relief sought by Plaintiffs need not involve account transfers, and even if it did it would be affecting applicants who are already delayed beyond the statutory period of adjudication only, this fear of backlogs is both overstated and inapposite to the relief sought by Plaintiffs.

Fourth, Defendants also worry that they simply cannot provide a determination to anyone who has been pending more than 45 days, citing possible challenges such as determining the immigration or citizenship status of the individual or verifying their income. DOMPI 40–41. Yet one thing is known for sure—since this lawsuit was filed, eleven individuals who could not get through the current system after having done everything humanly possible prior to filing suit, the named plaintiffs, now have TennCare because the State created a process that worked.

The State can, and has, helped people. And though determining Medicaid eligibility is not trivial, it is something that TennCare (and its predecessors) has been able to accurately assess for 45 years prior to 2014. The only material change to the *eligibility criteria* for Medicaid that were imposed by ACA involved adjustments to the calculation of qualifying income (the MAGI calculation). Thus, for example, immigration status can still be ascertained in the same way it had been previously through the Systematic Alien Verification for Entitlements ("SAVE") program, the way TennCare (through the Department of Human Services) did it prior to 2014;

indeed they are still enrolled in the SAVE system.[11] Zampierin Decl. ¶ 8 and Ex. 4. An individual's and household's income can be verified by TennCare, and if there is any ambiguity, an affidavit from the applicant can be accepted. 42 C.F.R. § 435.945; *see also* Medicaid Program Eligibility Changes Under the ACA, 77 Fed. Reg. 17144, 17173 (Mar. 23, 2012) (stating that if a State chooses to not use attestations and use data matching before determining eligibility, it is subject to the timeliness standards). And if it truly proves impossible for the State to determine when a person applied, it can accept an affidavit for that purpose as well. *Id.*

Fifth, the State worries that implementing this solution may divert there attention from other issues they view as more pressing. DOMPI 44. Again, this defies logic. The number one issue Defendants should be working on is making sure no application goes beyond the 45 or 90 day period, because this is the singular key failing of the current system. Had they resolved this already, they would not have, for example, had issues with presumptive eligibility for pregnant women (because by ensuring a prompt determination for these individuals, no one would have been improperly thrown off the TennCare rolls), or with newborns (who would have been able to be promptly enrolled without issue). Instead they have ignored this bigger issue and attempted to create smaller work-arounds for particular sub-groups. Rather than acknowledge and address the key issue of delay, Defendants continue to insist that their automated computer system, TEDS, is the answer, but they also refuse to even predict when it will be working. Gordon Decl. ¶ 6. They propose delaying providing any help to people whose applications are delayed so they can instead focus on a hospital presumptive eligibility program, but as noted above is unlikely to be

[11] SAVE "is a service that helps federal, state and local benefit-issuing agencies, institutions, and licensing agencies determine the immigration status of benefit applicants so only those entitled to benefits receive them." U.S. Customs and Immig. Svcs., *SAVE*, http://www.uscis.gov/save (last visited August 21, 2014). SAVE is routinely used for determination of benefits

approved and has no certain implementation date.

Of course, the real problem is *not* that the State cannot figure out how to do this. They know they can fix the problem, just as they have done for CoverKids, the state Child Health Insurance Program ("CHIP"). CoverKids also requires a MAGI determination. Because the State cannot currently do the MAGI determination in an automated process until TEDS is working, Defendants have instead adjusted the qualification rules for CoverKids so that it will be over-inclusive—as Wendy Long explains, "What this means is that someone who is not actually eligible [for CoverKids] under the new ACA rules could theoretically get on the program but no one who is in fact eligible will be denied. The determination was made that this solution was preferable to eliminating all direct applications to CoverKids and relying exclusively on the FFM." Long Decl. ¶ 16. But for TennCare Defendants picked a different approach—to eliminate nearly all direct applications[12] and to rely instead exclusively on the FFM, and continue to rely on that system without workarounds for some of its citizens when issues arose that were within their power to remediate. They could have instead used alternatives, such as self-attestations of applicants to provide any additional income or other verification needed, to allow eligible individuals to access TennCare while they waited for TEDS to start functioning, but they did not do so.

Put simply, no one—not the Plaintiffs, not the class members, and presumably not Defendants—are happy with the current situation. Everyone will benefit when the long-term solutions envisioned by the State are in fact implemented. But until that day comes, the State has a fundamental legal obligation to make eligibility determinations for those who have been waiting in line to long for services they need, and to provide a hearing when it does not do so

[12] Except, as noted above, for CHOICES and MSP applicants. *See supra* pp. 5–8.

within the time limits contained in federal law. Prioritizing fulfilling these legal and constitutional obligations are, of course, in the public interest. *See G & V Lounge, Inc. v. Mich. Liquor Control Comm'n*, 23 F.3d 1071, 1079 (6th Cir. 1994); *Glenwood Bridge, Inc. v. City of Minneapolis*, 940 F.2d 367, 372 (8th Cir. 1991).

IV. PLAINTIFFS' PROPOSED PRELIMINARY INJUNCTION ORDER IS APPROPRIATE.

Plaintiffs' proposed relief requests what is required by due process in situations where applicants have been pending for many months without being able to access services—a prompt determination, and an effective opportunity to be heard and that is reasonably calculated to inform individuals of their ability to seek a hearing when delayed. *Goldberg v. Kelly*, 397 U.S. 254, 268 (1970).

Defendants protest that the time constraints are too short, yet at the same time they insist that even if they were given a second 45-day window they still could not comply. What Defendants repeatedly fail to acknowledge is that they are legally required to have made a determination *in the first 45 or 90 days*, and thus even one day over is a violation.

Defendants further criticize the proposed notice to the MCOs as a "waste of time, effort and resources." Long Decl. ¶ 11. It would be neither. Plaintiffs request this notice so that the MCOs can inform providers of the new remedies available to persons pending beyond 45 or 90 days. Providers routinely interact with the MCOs, and have direct contact with individual applicants to TennCare who are seeking services or who have outstanding bills because their TennCare eligibility has not yet been determined.

Finally, Defendants criticize the proposed order because it is a tiered process that would require relief in 48 hours for Plaintiffs (who are known to Defendants), relief in 72 hours for any previously-unknown class member who presented herself to the Tennessee Health Connection

("TNHC"), and a remedial process whereby TennCare would affirmatively seek out all other persons pending beyond 45 or 90 days who had not self-identified by calling TNHC after the injunction was entered. Far from seeking "different relief," as Defendants suggest, the proposed order sets forth a workable framework that will ensure that all class members get the same relief—a long overdue determination on their TennCare application.

CONCLUSION

For the foregoing reasons, and as explained in Plaintiffs' motion and original memorandum in support, they respectfully request this Court grant their Motion for a Preliminary Injunction.

DATED August 21, 2014.

Respectfully submitted,

/s/ Christopher E. Coleman
On Behalf of Counsel for Plaintiffs

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CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing has been filed with the Court through the CM/ECF filing system, and that by virtue of this filing notice will be sent electronically to all counsel of record, this 21st day of August, 2014.

/s/ Christopher Coleman